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No. 93-510

IN THE
Supreme Court of the United States
OCTOBER TERM, 1993

AETNA LIFE INSURANCE COMPANY and
AETNA HEALTH MANAGEMENT,
Petitioners,

v.

STUART CIRCLE HOSPITAL CORPORATION,
Respondent.

On Petition for a Writ of Certiorari to the United States Court of Appeals for the Fourth Circuit

MOTION FOR LEAVE TO FILE BRIEF *AMICUS CURIAE* AND BRIEF *AMICUS CURIAE* OF THE NATIONAL COORDINATING COMMITTEE FOR MULTIEMPLOYER PLANS IN SUPPORT OF PETITIONERS

GERALD M. FEDER
DIANA L.S. PETERS *
KATHRYN L. BAKICH
FEDER & ASSOCIATES, P.C.
1350 Connecticut Avenue, N.W.
Suite 600
Washington, D.C. 20036
(202) 955-8305
Attorneys for National Coordinating Committee for Multiemployer Plans

* Counsel of Record

WILSON - EPES PRINTING CO., INC. - 789-0096 - WASHINGTON, D.C. 20001

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MOTION FOR LEAVE TO FILE BRIEF *AMICUS CURIAE*

To the Honorable Chief Justice and Associate Justices of the Supreme Court of the United States:

Pursuant to Rule 37 of the Rules of this Court, the National Coordinating Committee for Multiemployer Plans (the "NCCMP") respectfully moves this Court for leave to file the accompanying Brief *Amicus Curiae* to urge the Court to review the decision below, which raises an issue of great national importance with regard to ERISA pre-emption; more specifically, the scope of the "insurance regulation" exemption. Petitioners have consented to the filing of this Brief; Respondent has not. The letters granting and refusing consent have been filed with the Clerk of the Court.

The NCCMP is a nonprofit, tax-exempt organization that was formed after ERISA's enactment in order to participate in the further development of employee benefits legislation and the promulgation of government regulations to implement ERISA and other laws affecting multiemployer plans. Currently, more than 200 multiemployer plans and related international unions, located in at least 37 states, are affiliated with the NCCMP. These plans provide benefits to a majority of the more than nine million workers who are covered by the nation's multiemployer plans.

Because of the broad range of the NCCMP's constituent organizations and its contacts with hundreds of trustees charged with the administration of multiemployer plans in accordance with ERISA's fiduciary duty rules and principles, the NCCMP believes that it is qualified to advise the Court of the practical implications of the decision below for multiemployer health plans and to state the position of the trustees, participants, and beneficiaries of such plans. The NCCMP has participated as *amicus curiae* in numerous cases involving issues affecting multiemployer plans. *See, e.g., Local 144 Nursing Home Pension Fund, et al. v. Demisay*, —— U.S. ——, 113 S. Ct. 2252 (1993); *Concrete Pipe & Products of California v. Construction Laborers Pension Fund for Southern California*, —— U.S. ——, 113 S. Ct. 2264 (1993); and *FMC Corp. v. Holliday*, 498 U.S. 52 (1990).

In the instant case, we respectfully request this Court to review the important question whether Virginia's "any willing provider" statute, which regulates membership in Preferred Provider Organizations ("PPOs") marketed by insurers to employee benefit plans, is preempted by ERISA. The court below ruled that the law is "saved" from ERISA preemption because the statute regulates the "business of insurance," as distinct from the "business of insurers." The ruling thus expands the "savings" clause at the expense of the preemption clause by defining the "business

of insurance" in a manner inconsistent with this Court's precedents and Congressional intent. For this reason alone, the NCCMP urges review of the decision.

More specifically, multiemployer health plans, including many NCCMP affiliates, are increasingly utilizing the PPO form of managed care to respond to the escalating costs of providing covered health benefits. Cost containment is achieved through the PPO because the providers are able to deliver health care services at discounted rates. However, economic studies have shown that PPOs can deliver health care services at discounted rates only if membership is limited so that providers are assured sufficient patient volume to justify the discount. Such studies have demonstrated that the competition generated by limiting membership in PPOs also improves the quality of the health care they provide. The Virginia law, however, bars insurers from excluding any provider willing and able to meet the PPO's membership requirements, regardless of need.

The NCCMP submits that the decision below will have far-reaching adverse consequences for multiemployer health plans. If the Virginia law is upheld, PPOs offered by insurers will be eliminated from the market available to multiemployer plans both because they will not be able to provide the requisite discounts and because the trustees may not be able to perform their fiduciary obligation of assuring that the PPO selected is offering the highest quality health care at reasonable cost. Since states other than Virginia have or are considering "any willing provider" statutes, and since PPOs offered by insurers (including Blue Cross) are a large and reliable resource for multiemployer plans, elimination of such PPOs from the market available to multiemployer plans will undermine the viability of PPOs, in general, as a cost-containment mechanism in today's health care environment.

The NCCMP will focus its discussion upon the practical consequences of the decision below for multiemployer

plans, a topic on which the NCCMP is uniquely able to provide information.

Based on the foregoing, the NCCMP respectfully moves for leave to file the accompanying Brief *Amicus Curiae*.

Respectfully submitted,

GERALD M. FEDER
DIANA L.S. PETERS *
KATHRYN L. BAKICH
FEDER & ASSOCIATES, P.C.
1350 Connecticut Avenue, N.W.
Suite 600
Washington, D.C. 20036
(202) 955-8305
Attorneys for National Coordinating Committee for Multiemployer Plans

Dated: October 29, 1993

* Counsel of Record

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BRIEF *AMICUS CURIAE* OF THE NATIONAL COORDINATING COMMITTEE FOR MULTIEMPLOYER PLANS IN SUPPORT OF PETITIONERS

INTRODUCTION

The National Coordinating Committee for Multiemployer Plans (the "NCCMP") files this Brief *Amicus Curiae* to urge this Court to review the decision below, which contradicts the premises of ERISA preemption, is fundamentally inconsistent with previous decisions of this Court, and undermines the viability of Preferred Provider Organizations ("PPOs") as a cost-containment mechanism for multiemployer plans by effectively eliminating access to a whole class of PPOs.

INTEREST OF THE NCCMP

The nature, purpose, and interest of the NCCMP is set forth in the accompanying Motion for leave to file this brief.

SUMMARY OF REASONS FOR REVIEW

By enacting ERISA, Congress sought to enhance the financial stability of multiemployer plans and to foster the growth and maintenance of such plans. 29 U.S.C. § 1001. The decision below is inconsistent with those goals because it seriously limits the ability of plan trustees to respond to the national health care crisis—pending national health care reform—by freely selecting PPOs on a competitive basis to deliver high quality, low cost health care to plan participants and their families, and thereby to stem the drain on plan assets caused by escalating health care costs.

PPOs are intermediary organizations that arrange for third-party payers, such as employee benefit plans, to purchase health care for their subscribers or participants.[1] As such, PPOs may be viewed as a line of business that offers a product representing a variation of traditional fee-for-service arrangements. Like the latter, PPO administrators enter into contracts with health care providers to deliver the services covered by employee benefit plans at specified fees. However, because PPO administrators typically contract with a limited number of carefully selected health care providers, covered services can be delivered at substantially discounted rates since the preferred providers are assured a sufficient volume of patients to permit the discount.

In response to the spiraling costs of providing health care, self-funded multiemployer plans are increasingly utilizing or are considering utilizing PPOs to contain the

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[1] R. Youle and P. Daw, *Preferred Provider Organizations: An Antitrust Perspective*, Antitrust Bulletin (Summer 1984), p. 302.

costs of providing covered benefits. If the multiemployer plan has a sufficient number of participants in a geographical community, it may be feasible for the plan to establish its own PPO network in that locality and to negotiate directly with health care providers to secure the best possible rates. However, this is relatively unusual. Therefore, multiemployer plans must normally rely heavily on PPOs offered by insurance companies or on PPOs marketed by other entities such as associations of doctors or other health care providers.

At issue in this case is a Virginia law that regulates membership in PPOs offered by insurers such as Petitioners or Blue Cross (considered to be an insurer for purposes of the statute). Va. Code Ann. § 38.2-3407. Like the "any willing provider" statutes of other states, the Virginia law undermines the ability of these PPOs to deliver health care services to multiemployer plans at discounted rates because the statute prohibits the insurer from limiting the number of preferred providers; irrespective of need, the law prohibits the exclusion of any provider willing and able to meet the terms and conditions established by the insurer for membership in its PPO.

Although the Fourth Circuit agreed with the district court that the Virginia law "relates to" employee benefit plans and is therefore preempted under Section 514(a) of ERISA, 29 U.S.C. § 1144(a), the court of appeals held that the statute was "saved" from preemption under Section 514(b)(2)(A), 29 U.S.C. § 1144(b)(2)(A), because the statute regulates the "business of insurance," as distinct from the "business of insurance companies."

In so ruling, the court of appeals departed from this Court's consistent reading of the McCarran-Ferguson Act, 15 U.S.C. § 1101 *et seq.*, and its narrow construction of the "business of insurance." *Union Labor Life Ins. Co. v. Pireno*, 458 U.S. 119 (1982); *Group Life & Health Ins. Co. v. Royal Drug Co.*, 440 U.S. 205 (1979), *cert. denied*, 469 U.S. 1160 (1985). As a result, the court

unjustifiably expanded ERISA's "savings" clause at the expense of its preemption clause. If this decision stands and is followed, self-funded multiemployer plans will be exposed to a patchwork of state PPO regulations, since a number of states have or are considering laws similar to Virginia's. Under these laws, insurers cannot offer limited-panel PPOs to self-funded plans, even if it were practically and economically feasible to do so. The NCCMP seeks review because of its concern that the Fourth Circuit's ruling has impermissibly eroded the broad reach of ERISA preemption that Congress intended and that has been consistently upheld by this Court.

Whether or not the marketing and administration of a PPO constitutes the "business of insurance" for purposes of ERISA preemption is clearly an issue of great importance, as it adversely affects the ability of multiemployer plans to secure the delivery of health care at discounted rates by effectively eliminating a whole class of PPOs from the managed health care market available to such plans.

While it is true that "any willing provider" statutes like Virginia's do not regulate membership in PPOs, other than those established by insurers, PPOs established by insurers (including Blue Cross) form a major and reliable resource for multiemployer plans. Unless the Fourth Circuit's ruling is reviewed and reversed, however, multiemployer plans will no longer be able to utilize PPOs marketed by insurers in states having "any willing provider" statutes because those PPOs will not be able to deliver health benefits at discounted rates. Moreover, even if benefits could be provided at a reasonable discount, state laws such as Virginia's interfere with the fiduciary obligation of the trustees of multiemployer plans to ensure that the PPO it utilizes is of the highest quality and has an effective selection process for including and excluding providers.

Since it is well-established that limited-membership PPOs are intended to lower consumer prices by organiz-

ing only the most efficient health care providers, thereby permitting lower costs and higher quality through economies of scale, the elimination of PPOs offered or administered by insurance companies from the market open to multiemployer plans in states having "any willing provider" statutes is not only anticompetitive but inconsistent with the objectives of ERISA. The NCCMP therefore seeks review because there is no justification for including the marketing and administration of such PPOs within the definition of the "business of insurance" so as to save the Virginia law and similar state laws from ERISA preemption.

REASONS FOR REVIEW

THE DECISION BELOW WILL PLACE SERIOUS LIMITS ON THE ABILITY OF MULTIEMPLOYER PLANS TO SECURE HIGH QUALITY, COST-EFFECTIVE HEALTH CARE, RAISES AN ISSUE OF GREAT NATIONAL IMPORTANCE WITH REGARD TO ERISA PREEMPTION, AND IS INCONSISTENT WITH THIS COURT'S PREVIOUS DECISIONS

A. The Decision Below Diminishes the Viability of PPOs as a Cost-Containment Mechanism for Multiemployer Plans

The NCCMP endorses the reasoning of the district court [2] and therefore supports the arguments advanced in the Petition for Certiorari. In urging review, the NCCMP will focus primarily on the adverse impact which the Fourth Circuit's decision is likely to have on the ability

[2] *Stuart Circle Hospital Corp. v. Aetna Health Management*, 800 F. Supp. 328 (E.D. Va. 1992). The NCCMP also endorses the reasoning of Chief Judge Cacheris in a similar case, *HCA Health Services v. Aetna Life Ins. Co.*, 803 F. Supp. 1132 (E.D. Va. 1992), in which the court, in a lengthy and well-reasoned opinion, likewise concluded that Va. Code Ann. § 38.2-3407 was not saved from preemption because the statute does not regulate the business of insurance under this Court's tests.

of multiemployer plans to secure high-quality, cost-effective health care through contractual arrangements with PPOs—a perspective that the NCCMP is uniquely able to provide.

By way of background, it may be recalled that multiemployer health plans are created pursuant to collective bargaining agreements and are funded by contributions made by more than one employer, which are pooled to pay benefits on behalf of all of the plan's participants and beneficiaries. Employers and unions negotiate the amount of money they are willing to allocate to providing health benefits for their employees. However, the plan documents of multiemployer plans normally give trustees sole discretion to determine the type of benefits that the plan will provide as well as the amount of money the plan will pay for each covered benefit.

Typically, the plan of benefits enumerates the plan's eligibility requirements, the specific benefits covered, the specific benefits excluded, restrictions and limitations on the benefits provided (such as lifetime ceilings and coordination of benefits), the participant's obligations (including deductibles, copayments, and subrogation) and information concerning the submission of claims and the right to appeal. The contents of this plan are then summarized in a "summary plan description" which the plan must furnish to its participants in accordance with ERISA's reporting and disclosure requirements.[3]

While a multiemployer plan may utilize the services of a third-party administrator or an insurance company to administer the plan, benefit design issues are solely within the jurisdiction of the board of trustees, and only the trustees have the ability to determine whether a service is covered as a benefit under the plan. Analogizing to insured plans,[4] a multiemployer plan of benefits constitutes

[3] 29 U.S.C. §§ 1022, 1024(b).

[4] An "insured plan" is a plan in which group health coverage is provided through an insurance policy. Insured plans are subject

the insurance contract with its participants and beneficiaries because it sets forth the risks which the plan will assume (*e.g.*, covered benefits) as well as those which remain with the participant (*e.g.*, limitations on coverage, exclusions, specific obligations).

In an effort to control costs while ensuring that high quality medical care is available for their participants and beneficiaries, multiemployer plans are increasingly utilizing or are considering utilizing PPOs or some other form of managed care.[5] Economic studies[6] have shown that man-

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to state regulation of insurance companies. However, self-funded plans are "deemed" not to be insurers for purposes of state laws regulating insurance and are therefore not bound by state laws regulating insurance. 29 U.S.C. § 1144(b)(2)(B). *See Metropolitan Life Ins. Co. v. Massachusetts*, 471 U.S. 724 (1985) and *FMC Corp. v. Holliday*, 498 U.S. 52 (1990). The court below clearly recognized this distinction, noting that the Virginia law regulating membership in the PPOs of insurers could not prohibit self-funded plans from establishing limited-membership PPOs themselves or from utilizing limited-membership PPOs marketed by noninsurers. However, the "deemer" clause, which normally affords self-funded plans significant protection against state laws, is of no practical significance with regard to "any willing provider" statutes because insurance companies do not have separate networks for insured and self-funded plans. Moreover, since the Virginia law does not focus on the *purchaser* of the PPO, it would appear to bar insurers from offering limited-memership PPOs to self-funded plans, even if the insurer could establish and market separate PPO networks, *infra*.

[5] Managed care involves control over quality, utilization, and claims and can be provided through a variety of forms such as PPOs, HMOs, or some variation thereof. The use of PPOs has increased so dramatically within the managed health care industry that an accreditation program has now been established just for PPOs. Major foci of the accreditation process are provider selection and quality assessment. As one reviewer has stated, "Most doctors see managed care as having strictly a cost-saving emphasis. Though that's obviously important, no matter how much money a PPO saves, there still must be an emphasis on quality." *See* Nancy N. Bell, *The AAPI Accreditation Program*, Medical Interface (April 1991), pp. 23, 27.

[6] *See, for example, Report to Health Insurance Association of America: Cost Analysis of State Legislative Mandates on Six*

aged care plans, including PPOs, are much better able to control costs than traditional fee-for-service [7] or indemnity

Managed Care Practices (Wyatt Company 1991); *see also* Letter of Michael O. Wise, Acting Director of the Federal Trade Commission to the Attorney General of Montana, dated February 4, 1993, discussing the anticompetitive and cost-increasing effects of "any willing provider" laws. The principal purpose of Mr. Wise's letter was to set forth the views of the staff of the Federal Trade Commission with regard to Montana's "any willing provider" statute, Mont. Code Ann. § 33-22-1704 (Temporary), due to expire in July 1993. The letter indicates that, as a general principle, PPOs moderate increases in health care costs and that lower premiums are attributable to competition among health care providers. Conversely, since "any willing provider" statutes are anticompetitive, FTC staff believes that these laws may result not only in increasing consumer prices but in restricting consumer choice if PPOs are unable to deliver health care at discounted rates. (Since the Montana statute is similar to Virginia's, the above letter has been reprinted in full as Appendix E to the Petition (35a-43a).)

Similarly, as reported by The Segal Company, a recent survey by *Business Insurance* magazine has found that plans renewing their contracts in mid-1993 are experiencing 18-22 percent increases in premiums for indemnity coverage, as contrasted with 12-18 percent increases for PPOs. *See Managed Care for Multiemployer Plans: Experience and Outlook*, The Segal Company Newsletter, Vol. 37, Nos. 2 and 3 (Sept. 1993), pp. 3-4. (The Segal Company is a nationally known consultant to multiemployer plans, including numerous NCCMP affiliates, and works with plans to obtain high quality care at reasonable cost.)

It may also be noted that the previous Administration, utilizing demonstration models, has sought to establish PPOs as an arrangement to improve the delivery and cost of health care services provided to participants in the Civilian Health and Medical Program of the Uniformed Services (CHAMPUS). The Department of Defense has noted that both the beneficiary and the program sponsor can stand to benefit because of discounts offered by PPO providers, and that providers stand to benefit by increasing their market share. 53 Fed. Reg. 19323-01 (1988).

[7] "Fee-for-service" refers to a traditional means of billing by health care providers for each service performed. PPOs achieve cost-savings because network providers agree to provide services on a fee-for-service basis at a discounted rate. The reduction may consist of a percentage of the plan's fee schedule based on what

plans. In 1990, for example, 27 small multiemployer plans covering primarily building trades workers in Washington, D.C., Baltimore, Maryland, and Richmond, Virginia, established an organization to negotiate lower rates with PPOs, prescription drug programs, and utilization services. The plans provided health care coverage to approximately 25,000 workers and 50,000 eligible dependents. In the first year of its operation, the Health Care Cost Containment Corporation of the Mid Atlantic Region ("HCCCC") saved the plans a total of $12 million: $4.66 million (38 percent) in physician costs, $3.85 million (32 percent) in hospital costs, and $3.49 million (29 percent) through utilization management. According to The Segal Company, total negotiated discounts in the first quarter of 1993 reached nearly $5 million. As of July 1993, 41 funds covering 43,000 workers now participate.[8]

The trustees of plans selecting the PPO form of managed care frequently adopt a PPO plan in combination with a non-PPO plan, permitting the participant to select which plan he or she desires to utilize to obtain health care. In this case, participants are free to use any of the physicians or health care facilities within the PPO network. Although participants are not penalized or prevented from using non-PPO providers, the PPO plan will generally include important incentives that encourage its use,

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is "usual" (the provider's normal charge), "customary" (the normal charge for similar providers in the area), and "reasonable" (the charge the plan is prepared to pay, also referred to as the "allowable charge" for the service). Or, cost-savings may be achieved through independently negotiated fee schedules; for example, based on the number of "bed days" rather than itemized hospital charges. Or, the PPO providers may agree to accept a reduced percentage of a plan's standard fee schedule based on relative value scales. Relative value scales establish uniform charges for all procedures and services based on the perceived value of those procedures and services with respect to one another.

[8] The Segal Company Newsletter, *supra*, pp. 11-12.

so as to permit the plan to take advantage of the cost-savings generated by the use of PPOs.

The following example, provided by an NCCMP affiliate, illustrates the operation of a combined PPO non-PPO plan and the incentives for a participant's remaining within the PPO network:

> A participant seeks care for a heart ailment. The participant's physician recommends that a mitral valve replacement be performed. The Trustees determine that mitral valve replacement is a procedure covered by the plan and that the participant is eligible for benefits. The plan's utilization review board certifies that the procedure can be performed within the PPO network.[9]
>
> If the participant receives mitral valve replacement at a PPO hospital, the participant will be reimbursed at the rate of 80 percent of allowable (*e.g.*, contracted) charges for hospital care and 80 percent of allowable (*e.g.*, contracted) charges for the surgeon. The participant pays the remaining 20 percent.
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> If the participant goes outside of the PPO for the mitral valve procedure, the participant will be reimbursed at the rate of 60 percent of the plan's fee schedule for the procedure; the participant will pay 40 percent. However, regardless of the cost of

[9] Managed care programs usually include a utilization review system ("UR"), which provides for preadmission hospital review, second surgical opinions, review during hospital stays, and alternative treatment options (for example, outpatient versus inpatient). UR programs contain costs by determining whether a treatment is appropriate and necessary and also, where such services should be provided. As a matter of plan design, the decision to adopt a UR program lies within the sole discretion of the trustees. Typically, the fund will then contract with a third party, other than the PPO, to provide UR. If the UR provider determines that a particular procedure cannot be performed within the PPO network, participants will usually be permitted to obtain treatment from a non-PPO provider without incurring the penalties that otherwise provide the incentive to remain within the PPO.

> the hospital and surgical fees, the plan will pay only a maximum of $15,000 per hospital stay and $8,000 to the surgeon for the mitral valve replacement.

In this example, the participant not only pays a 20 percent larger share of the costs of the treatment; he or she may also be required to pay a higher share of a higher charge.[10] In addition, benefits are capped, which is very significant in the event of major illnesses.

If a multiemployer plan has a sufficient number of participants in a particular geographical location, the plan may be able to establish its own PPO network by negotiating directly with health care providers to obtain the best terms possible. This is the exception, not the rule, particularly since the American Accreditation Program, Inc. ("AAPI"), the accrediting vehicle of the American Association of Preferred Provider Organizations ("AAPPO"), will not accredit a PPO unless it provides services to at least 6,000 participants, and PPOs are relatively circumscribed geographically in order to provide reasonable access to health care providers.

Therefore, multiemployer plans adopting the PPO-form of managed care must rely on insurers such as Petitioners or Blue Cross or other insurers who market or administer PPOs. As amply pointed out by Petitioners and in the literature cited in their brief, including the opinion of FTC staff, PPO's are able to deliver health care at discounted rates only if the PPO is able to limit its mem-

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[10] An example of this would be where a hospital PPO arrangement provides for reimbursement of all hospital costs based on "bed days," whereas the non-PPO plan has standard charges for specific procedures. Assume the usual, customary, and reasonable charge for a procedure is $15,000, but the PPO plan pays $900 per bed day. The participant has the procedure performed in a hospital and stays three days. If the participant chooses the PPO provider, he will be liable (at most) for 20 percent of $2,700 (3 × $900) or $540. If the participant chooses a non-PPO provider, he will be liable for 40 percent of $15,000 or $6,000. Clearly, the plan and the participant save by utilizing a PPO hospital.

bership to assure a sufficient volume of patients to justify the discount.[11]

"Any willing provider" statutes, such as Virginia's, prohibit PPOs from limiting the number of providers. As stated in the FTC opinion letter,

> Requiring that programs be open to all providers wishing to participate on the same terms may affect both costs and coverage. To the extent that opening programs to all providers reduces the portion of subscribers' business that each contracting provider can expect to obtain, these providers may be less willing to enter agreements that contemplate lower prices or additional services. Moreover, since any provider would be able to contract on the same terms as other providers, there would be little incentive for providers to compete in developing attractive or innovative proposals. Because all other providers can "free ride" on a successful proposal formulation, innovative providers may be unwilling to bear the costs of developing a proposal. Thus "any willing provider" requirements may substantially reduce provider competition for this segment of their business.

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[11] One NCCMP affiliate reports that it gradually phased in a PPO network, with both physicians and hospitals, as follows. The plan originally reimbursed physicians under a standard fee-for-service plan at a rate that was within the 85th percentile of the fee schedule adopted by the trustees, which was based on the California Relative Value Scale. In an attempt to control costs, the plan reduced the amount of reimbursement from the 85th percentile to the 70th percentile. However, in order to achieve more significant cost-savings, the plan contracted with an insurance carrier to purchase a PPO for the geographic area in which its participants were located. The PPO saved approximately 2 percent in physician costs. However, the PPO saved approximately 15 percent in hospital costs. It is anticipated that this PPO network will be decreased from several thousand to several hundred physicians. Cost-savings to be derived from downsizing the PPO network are expected to amount to an additional 5 to 10 percent. While the physicians in the smaller PPO will receive lower reimbursement, they will receive a greater volume of business.

> Reduced competition among providers for PPO business can result in higher prices for services through PPOs. The higher prices for covered services, as well as the increased administrative costs associated with having to deal with many more providers, may raise the prices to subscribers for prepaid health care programs, or may force those programs to reduce benefits to avoid raising those prices. (Petition, App. E, 41a-42a.)

Similarly, The Wyatt Company's evaluation of the impact of "any willing provider" statutes on administrative costs- and claims-savings concluded that a point exists where a PPO will be unable to sustain any marginal value to the community if it is forced to accept more than a limited percentage of providers, assuming that the average provider must either increase utilization or accept smaller discounts to maintain the current level of net income or operating margins.[12]

The NCCMP has been advised by various insurers that insurance companies in states having "any willing provider" statutes do not have separate PPO networks for multiemployer plans. Moreover, the Virginia law makes no distinction between PPOs offered to self-funded multiemployer plans and PPOs offered to other subscribers. Therefore, even if it were economically or administratively feasible for an insurer to offer different PPO networks to different subscribers, the Virginia law would not permit the insurer to exclude willing providers merely because the insurer is offering the network to a multiemployer plan.

Consequently, although "any willing provider" laws, such as Virginia's, were apparently designed to give consumers an unlimited choice of providers, such laws, if allowed to stand, will have the opposite effect on multi-

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[12] *Report to Health Association of America: Cost Analysis of State Legislative Mandates on Six Managed Care Health Practices* (Wyatt Company, 1991).

employer plans and their participants and beneficiaries. First, multiemployer plans wishing to adopt the PPO form of managed care will have to rely on PPOs other than those marketed by insurers in states having such laws. Or, these plans will have to utilize other forms of managed care. In either case, consumer choice will be reduced. In addition, since PPOs offered or administered by insurers represent a very large resource, elimination of these PPOs from the market available to multiemployer plans is likely to result in lower discounts, since the remaining PPOs will be better able to adopt a "take it or leave it" posture, given the reduced competition. This, too, will adversely affect the consumer.

Moreover, as the AAPPO and its accrediting vehicle, the AAPI, recognize, quality is as important a factor as cost-containment. Indeed, this factor is particularly important with regard to multiemployer plans governed by ERISA, whose trustees have a fiduciary obligation to select PPOs that are not only cost-effective but provide the highest quality care, and to monitor—either themselves or through the entity offering the PPO—the providers delivering services to plan participants.

Apart from cost, bigger PPOs are not necessarily better because the selection criteria may not be very stringent. "Any willing provider" laws exacerbate the problem of quality control because PPOs offered by insurers must include even marginal providers as long as they satisfy the basic membership criteria instead of limiting membership to the best providers having an established track record of providing high quality care at reasonable cost. If the PPO cannot demonstrate that it is committed to identifying and, if necessary, terminating inferior or aberrant providers, notwithstanding the risk of lawsuits, the trustees of multiemployer plans may not be able to assure the quality of service in a manner sufficient to comply with ERISA. For this reason too, "any willing provider" statutes may result in the elimination of PPOs offered

by insurers from the market available to multiemployer plans. The effect of "any willing provider" statutes on the financial soundness of multiemployer plans is therefore an issue of great national importance, since numerous states have or are considering such laws.[13]

The NCCMP also seeks review because of its fundamental belief that the health care crisis must be resolved by national health care reform, not by piecemeal state legislation which, if enforced by federal courts, could cripple multiemployer plans. In this regard, it is significant that the President's Health Care Reform Plan endorses limited-provider plans. Thus, while corporate alliances may offer a traditional indemnity plan, they must also offer at least two other plans. *Notwithstanding state laws to the contrary*, such plans are authorized to:

- Limit the number and type of health care providers who participate in the health plan.
- Require participants to obtain health services other than emergency services from participating providers or from providers authorized by the health plan.
- Establish different payment rates for participating health providers and providers outside the plan.
- Create incentives to encourage the use of participating providers.
- Use single-source suppliers for pharmacy, medical equipment, and other health products and services.[14]

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[13] As noted in Petitioners' brief, the following states already have "any willing provider" statutes similar to Virginia's: Georgia, Illinois, Indiana, Louisiana, Utah, and Wyoming. According to a report issued by the Group Health Association of America, dated September 15, 1993, 15 states have or are introducing some form of "any willing pharmacy" law. If the Fourth Circuit's opinion is sustained, other states may be encouraged to expand such laws to regulate membership in PPOs.

[14] *Clinton Administration Description of President's Health Care Reform Plan, American Health Security Act of 1993, dated Sep-*

Since "any willing provider" laws are inconsistent with the goals of national health care reform, and are demonstrably anticompetitive, there is no justification for "saving" these state laws from ERISA preemption, particularly since the marketing and administration of PPOs by insurance companies is clearly not the "business of insurance" under this Court's precedents.

B. The Decision Below Raises an Issue of Great National Importance With Regard to ERISA Preemption and Is Inconsistent With This Court's Precedents

This Court has repeatedly emphasized that "ERISA preempts any state law that refers to or has a connection with covered benefit plans (and that does not fall within a § 514(b) exception) even if the law is not specifically designed to affect such plans, or the effect is only indirect." *District of Columbia v. Greater Washington Board of Trade*, 506 U.S. ——, 121 L.Ed.2d 513, 520 (1992) (citations omitted). The issue in this case is therefore whether Virginia's "any willing provider" law falls within a § 514(b) exemption since there is no dispute that the law "relates to" employee benefit plans.

Section 514(b)(2)(A) exempts from preemption state laws that "regulate insurance." However, ERISA does not further define insurance regulation. Therefore, to determine whether a state law falls within the § 514(b) insurance exemption, this Court and all lower courts faced with the issue have drawn upon the criteria for determining whether a particular practice constitutes the "business of insurance" within the meaning of the McCarran-Ferguson Act, 15 U.S.C. § 1011 *et seq.* If the state law regulates a "practice" that constitutes the "business of insurance," it is saved from ERISA preemption, except as applied to self-funded employee benefit plans. *See Metropolitan Life Ins. Co. v. Massachusetts*, 471 U.S.

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tember 7, 1993, BNA Special Supplement (September 13, 1993), S-25.

724 (1985) (holding that state-mandated benefit laws are saved from preemption, except as applied to multi-employer plans, because they regulate the substantive terms of insurance contracts and otherwise meet the McCarran-Ferguson criteria).

In the case at bar, the Fourth Circuit ruled that PPO arrangements between insurers and service providers constitute the "business of insurance." The court therefore ruled that the Virginia law, which regulates membership in PPOs offered by insurers, is "saved" from ERISA preemption. The NCCMP concurs fully with Petitioners that the Court below failed to distinguish between the "business of insurance" and the "business of insurers" and, in so doing, departed from the distinction carefully crafted by this Court in *Group Life Health Ins. Co. v. Royal Drug Co.*, 440 U.S. 205 (1979) and *Union Labor Life Ins. Co. v. Pireno*, 458 U.S. 119 (1982).

Specifically, the NCCMP agrees with Petitioners that *Royal Drug* is dispositive of the case at bar. In *Royal Drug*, this Court ruled that certain pharmacy agreements, which permitted Blue Shield's insureds to purchase prescription drugs from participating pharmacies more cheaply and more conveniently than from nonparticipating pharmacies, did not constitute the "business of insurance" for purposes of the McCarran-Ferguson Act, 15 U.S.C. § 1011 *et seq.* In making this determination, the Court stated, first, that the pharmacy agreements between Blue Shield and the pharmacies did not underwrite or spread the policyholder's risk, an indispensable characteristic of insurance, because they were merely the vehicle by which Blue Shield could deliver the promised or insured benefit (*e.g.*, prescription drugs) at lower cost to itself and to its policyholders. Second, the Court found that the agreements were not part of the integral relationship between Blue Shield and its insureds, since the contracts were not *between* the insurer and the insured. Finally, the Court found that the agreements did not constitute the "business

of insurance" because they were separate contractual arrangements for goods and services with third persons wholly outside of the insurance industry. The Court indicated that even if Blue Shield acquired its own chain of drugstores to further lower the costs of meeting its obligations to policyholders, this would not be the "business of insurance."

The PPO arrangements between insurers and the health care providers which these insurers accept for membership in their PPOs are the functional equivalent of the pharmacy agreements in *Royal Drug*. First, the PPO contracts do not underwrite risk; they merely serve as the vehicle through which third-party payers, such as employee benefit plans, may fulfill their obligation to provide covered benefits at lower cost to themselves and their participants. Second, the PPO contracts do not regulate the relationship between the insurer and the insured, but only the relationship between the insurer and the preferred provider. Finally, the PPO contracts are not limited to persons or entities in the insurance industry, since the preferred providers themselves are wholly outside this industry. Accordingly, the PPO contracts cannot be reasonably construed to constitute the "business of insurance." Therefore, the Virginia law which regulates these contracts should not be saved from ERISA preemption, as the district court correctly found.

The NCCMP submits that review is necessary to restore the "business of insurance" definition to the precise and narrow limits intended by Congress and articulated by this Court to protect multiemployer plans from a patchwork of state regulation, which protection Congress sought to provide by making employee benefit plans the exclusive concern of federal law.

CONCLUSION

Limited-membership PPOs are essential to contain costs in today's health care environment, and have already been endorsed by the Administration in its proposal for national health care reform. Conversely, open-membership PPOs, which "any willing provider" statutes are designed to protect, are anticompetitive and inconsistent with the objectives both of the McCarran-Ferguson Act and ERISA. The Court below, misconstruing this Court's precedents, upheld Virginia's law by construing PPO arrangements as the "business of insurance." The Court thereby expanded ERISA's savings clause (§ 514(b)(2)(A)) at the expense of ERISA's preemption clause (§ 514(a)), and issued a ruling inimical to the financial health of multiemployer plans.

For the reasons stated above, the Court should grant the Petition for Certiorari and review the decision of the Court below.

Respectfully submitted,

GERALD M. FEDER
DIANA L.S. PETERS *
KATHRYN L. BAKICH
FEDER & ASSOCIATES, P.C.
1350 Connecticut Avenue, N.W.
Suite 600
Washington, D.C. 20036
(202) 955-8305
Attorneys for National Coordinating Committee for Multiemployer Plans

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* Counsel of Record